NEW GUIDANCE AIMS TO IDENTIFY PEOPLE AT RISK OF EARLY DEATH

NICE public health guidance recommends case-finding people most at risk of premature death from cardiovascular and other smoking-related diseases. Nerys Hairon reports

NICE has launched public health guidance to reduce premature death rates in disadvantaged areas, focusing on proactive case-finding (NICE, 2008a). The guidance recommends a number of ways, such as health sessions in community venues, to identify disadvantaged people who are at high risk of cardiovascular disease and other smoking-related diseases.

The guidance contributes to a government drive to tackle health inequalities, and contains recommendations for smoking cessation services and statin provision. It was published just before the Department of Health announced the UK would be the first EU country to put picture warnings on all tobacco products (DH, 2008). From this month, these replace written warnings.

Nurses are vital in case-finding disadvantaged people at a high risk of dying prematurely and in gaining their trust and establishing positive relationships with them.

BACKGROUND

NICE’s (2008a) guidance outlines what works in finding and supporting those most at risk of early death and improving access to services. The guidance points out that people who have a lifetime of advantage are likely to live longer and healthier lives than those who are disadvantaged (Graham and Power, 2004).

Despite increases in affluence and lower mortality among some population groups, cardiovascular disease, other smoking-related diseases and smoking are still more prevalent among lower socioeconomic and certain minority ethnic groups compared with the general population.

The guidance applies to people in disadvantaged areas and all those who are disadvantaged, regardless of where they live. For definitions of disadvantaged adults, see box (p22). Local agencies such as PCTs define disadvantaged areas in a number of ways. The Index of Multiple Deprivation 2007, which combines indicators on economic, social and housing issues to produce a single deprivation score, is one system used.

According to NICE (2008b) guidance, a person is deemed to be at a high risk of cardiovascular disease (CVD) if they have a 20% or higher risk of a first cardiovascular event in the next 10 years. NICE (2008a) explains that smoking cessation and statin interventions were used as the basis of the recommendations because both are generally agreed to be effective and cost-effective. Since epidemiological data shows a clear socioeconomic gradient for smoking and CVD, tackling smoking and providing statins (as recommended) should make a significant contribution to reducing health inequalities.

The guidance points out that health inequalities are ‘so deeply entrenched’ that improving services and access to them can only be one part of a broader strategy. The recommendations focus on system and structural changes, which require a comprehensive approach at all levels of the health system.

RECOMMENDATIONS

This public health guidance (NICE, 2008a) should be used alongside NICE guidance on smoking cessation, lipids and statins (see www.nice.org.uk for details).

It contains recommendations in five main areas: identifying adults at risk; improving services; system incentives; partnership working; and training and capacity. The recommendations on identifying people at...
Methods to identify disadvantaged people at a high risk of CVD include:
- Health sessions at a variety of community and public venues, including post offices, charity shops, supermarkets, pharmacies, homeless centres and workplaces, as well as prisons and long-stay psychiatric units;
- Culturally sensitive education sessions that include a CVD risk assessment and take place in BME community settings, including places of worship;
- Outreach activities provided by community health workers.
Service providers should monitor these methods and adjust them accordingly, and also encourage all disadvantaged people to register with a GP practice.

Improving services
Service providers such as GP practices and PCTs should provide flexible, coordinated services that meet the needs of disadvantaged people. These could include drop-in or community services, outreach and out-of-hours services, advice and help in the workplace and single-sex sessions.

The guidance emphasises that it is important to gain the trust of disadvantaged adults and offer support. This could include helplines, brochures and invitations to attend services. Non-judgemental programmes, tailored to people’s needs, should be developed to tackle social and psychological barriers to change.

GP practices and PCTs should ensure that services are sensitive to culture, gender and age. An example is providing multilingual literature in a culturally acceptable style and involving community, religious and lay groups in its production. Translation and interpretation facilities should be offered. Services should be provided in places that are easily accessible for disadvantaged people (such as pharmacies and shopping centres). Patients should be given support to ensure they can attend appointments, and encouraged to follow treatment (for example through self-management techniques).

GP practices should routinely search their databases to identify patients who have not collected repeat prescriptions or attended follow-up appointments, and contact them.

Partnership working
The guidance recommends that planners, commissioners and service providers (including GP practices and PCTs) should develop partnerships with professionals and community workers who are in contact with disadvantaged people. Service providers should establish relationships between primary care practitioners and the community. They should also establish relationships with practitioners in acute care to help identify patients at a high risk of further cardiovascular events.

Incentives and training
The target populations for these two areas are service providers themselves. Policymakers, planners and commissioners should support and sustain activities aimed at improving the health of disadvantaged people. They should also provide incentives for local projects that improve the health of disadvantaged people.

In the area of training, commissioners and service providers should ensure there are enough practitioners with the necessary skills to help disadvantaged people adopt healthier lifestyles. They should also ensure that practitioners have the skills to identify disadvantaged people and can develop services to meet their needs.

CONCLUSION
The NICE (2008a) guidance outlines several ways to reach people who are at most at risk of premature death. Nurses can help to tackle health inequalities by implementing this proactive case-finding approach through a variety of methods.

Identifying at-risk adults
Primary care professionals should use a range of methods to identify disadvantaged adults at a high risk of premature death from CVD. These methods include:
- Primary care and GP registers (for example to identify smokers; people from particular black and minority ethnic groups; or people with family members who have had premature coronary heart disease);
- Primary care appointments (for example during routine visits and screening);
- Systematic searches in pre-identified areas or with specific populations;
- Analyses of quality and outcomes framework (QOF) data.

**Disadvantaged People**
- Disadvantaged adults include but are not limited to:
  - People on a low income (or who are members of a low-income family);
  - Those on benefits;
  - People living in social housing;
  - Some members of BME groups;
  - Those with a mental health problem;
  - People with a learning disability;
  - Those who are institutionalised (including those in prison);
  - Homeless people.

Source: NICE (2008a)